STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF CARMEL	11610 TECHNOLOGY DR CARMEL, IN 46032

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R0000	This visit was for a State Residential Licensure survey. Survey dates: February 11 and 12, 2013 Facility number: 012309 Provider number: 012309 AIM number: N/A Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Census bed type: Residential--30 Total--30 Census payor type: Medicaid--15 Other--15 Total--30 Sample: 8 These state findings are cited in accordance with 410 IAC 16.2. Quality Review completed by Tammy Alley RN, on February 19, 2013.	R0000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an Admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and Submitted because of State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to evaluate the needs of 2 residents for issues of continued arm pain and weight gain, in a sample of 8 residents reviewed. [Residents #25 and #50] Findings include: 1. The clinical record for Resident #25 was reviewed on 2/12/13 at 10:00 A.M. Diagnoses included, but were not limited to, congestive heart failure, arteriosclerotic heart disease, history of acute renal failure, and chest pain. An "Interdisciplinary Progress Notes" entry, dated 9/2/12 at 7:45 A.M., indicated "Went in to awake [name of resident] for breakfast. Stated that her arms were hurting...." The entry was signed by Q.M.A. (Qualified Medication Aide) #4. A subsequent entry at 1:00 P.M., signed by the same Q.M.A., indicated "Went in to ask if she was coming out for lunch.	R0214	1.The physician of resident #25 was notified of the complaint of arm pain and orders followed. The physician of resident #50 was notified of the weight changes and new orders were followed. 2.No other residents were identified as having a substantial change in condition, warranting evaluation by a licensed nurse. All residents with who undergo a substantial change in condition could be affected, thus, the following corrective actions were taken. 3.All licensed nurses and QMAs were addressed in regard to notification of the licensed nurse should the resident voice a change in condition or the QMA observe a situation indicative of resident change in condition. The licensed nurse is then responsible to evaluate and to make necessary notification and/or seek physician evaluation and treatment, as warratned. The 24 hour report sheet will be reviewed and initialed by the DON or designee daily on regularly scheduled days ongoing to	02/28/2013

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	She stated that she didn't feel well...." A progress note dated 9/3/12 at 7:00 A.M., signed by Q.M.A. #4, indicated "Stayed in bed for A.M. Complained pain in arms hurting. She refused to come out for breakfast so sent in a tray...." A note on 9/3/12 at 12:00 P.M., signed by Q.M.A. #4, indicated "Went in to get her for lunch and she was crying saying that her arms were hurting her bad and she had trouble getting dressed and to the bathroom, so I assisted her to the restroom and also down to lunch." A progress note dated 9/4/12 at 10:00 A.M., signed by Q.M.A. #4, indicated "Went in to awake [resident's name] for breakfast. She complained of pain to her arms. She refused to come out...." There was no documentation that the resident's arm pain had been evaluated on any of these 3 days. There were no subsequent progress notes related to arm pain until 11/6/12 at 4:00 P.M. An entry, signed by LPN #5, indicated "Resident complained of severe pain to right arm/shoulder 'everywhere'. Resident called own doctor. Writer spoke to M.D. Order received for X-Ray: right shoulder,		ensure all changes in condition are addressed appropriately. Upon review, the DON or designee will ensure a proper assessment has been completed for changes in condition and the physician will be notified accordingly. 4.As a means of quality assurance the DON or designee will complete the above described monitoring ongoing on a daily basis on regularly scheduled days of work. Should a deficient practice be observed, immediate corrective action will be taken. Additionally, the Administrator or designee will monitor and sign off on the 24 hour report sheets monthly ongoing. Based upon monitoring, the plan of correction will be revised accordingly, if warranted	

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	humerus, elbow, ulna, radius... ." The February 2013 physician order recapitulation listed medications that included, but were not limited to, PRN (as needed) medications of Norco 10/325 (a pain medication) one tablet every 8 hours as needed, and Nitrostat (a chest pain medication) 0.4 mg. as needed. In an interview during the daily conference on 2/12/13 at 1:20 P.M., LPN #5 indicated she could not recall any arm pain issues in September, but did remember the issue in November. She indicated she would have to review the clinical record for more information. At the exit conference on 2/12/13 at 3:45 P.M., LPN #5 indicated she had no additional documentation related to an evaluation of the resident's arm pain in September, 2012. 2. The closed clinical record for Resident #50 was reviewed on 2/11/13 at 12:25 P.M. The resident was originally admitted to the facility on 3/27/12 with diagnoses that included, but were not limited to, hypertension, congestive heart failure, morbid obesity, and diabetes. The resident was discharged to a			

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	skilled nursing facility on 2/8/13. The resident's weights were documented as follows: May, 2012--285 June, 2012--282 July, 2012--286 August, 2012--306 A note added next to the weight indicated "Dr. [name] aware." August, 2012--314 September, 2012--315 October, 2012--317 November, 2012--310 December, 2012--318 January, 2013--321 A progress note from the Nurse Practitioner, dated 8/23/12, indicated "Saw patient today. Evaluated increased weight gain, increased confusion... extremities: 1+ pitting edema to knee... Start Lasix...." Other subsequent evaluations of the resident's weight gain by the facility or Nurse Practitioner were not found. In an interview on 2/12/13 at 1:25 P.M., LPN #5 indicated the 8/23/12 note from the Nurse Practitioner was the only documentation she could find related to the resident's weight gain.			

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R0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to address current issues for 3 out of 8 residents reviewed for service plans in a sample of 8. (Resident # 13, Resident #27, and Resident #25) Findings include:	R0217	1.The services plans of residents #13, 27 and 25 were reviewed and updated to include current issues and interventions. 2.All residents have the potential to be affected. All residents will have their service plans reviewed and updated to ensure all current issues and interventions are addressed.	02/28/2013

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	1. The clinical record for Resident #13 was reviewed on 2/11/13 at 10:30 A.M. Diagnoses included, but were not limited to, end stage congestive heart failure, high blood pressure, hypothyroidism, benign prostatic hyperplasia and osteoarthritis. The clinical record indicated the resident had difficulty with urination and had a foley placed by his physician on 11/12/2012. The document titled "Level of Service Assessment/Evaluation" indicated on November 12, 2012 the resident "...Needs assistance daily to manage catheter...." The document titled "Evaluation of Needs/Service Plan for Resident" was dated December 11, 2012, with the most recent update December 10, 2012. The document did not indicate what type of service they were providing to the resident related to the resident having a Foley catheter. In an interview on 2/12/13 at 2:30 P.M., the Director of Nursing indicated the "Level of Service Assessment/Evaluation" document was not the service plan but how they decided which level of care the		3.The DON or designee will review and update all service plans on a quarterly basis and as needed with changes. The DON or designee will complete an ongoing audit on a monthly basis of at least three (3) service plans to ensure all service plans are updated with current issues and interventions. 4.As a means of quality assurance the DON or designee will complete the above described monitoring ongoing on a monthly basis. Should a deficient practice be observed, immediate corrective action will be taken. The Administrator will monitor and sign off on the monitoring tools monthly ongoing. The plan of correction will be revised accordingly, and number of audits increased or decreased, as warranted.	

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	resident needed. She indicated the Evaluation of Needs/Service Plan was the document they used as their service plan. She indicated there was nothing on the service plan about the resident's Foley. 2. The clinical record for Resident #27 was reviewed on 2/12/13 at 9:45 A.M. Diagnoses included, but were not limited to, early congestive heart failure, history of colon cancer and diverticulitis, depression, psychotic episodes, right sided heart failure and acute renal failure. The resident was admitted on 6/3/2011. The document titled "Level of Service Assessment/Evaluation" indicated on July 26, 2012 the resident "...Needs assistance daily with colostomy care...." The document titled "Evaluation of Needs/Service Plan" was dated July 26, 2012, with the most recent update January 8, 2013. The document did not indicate what type of service they were providing to the resident related to the resident having a colostomy. In an interview on 2/12/13 at 2:32 P.M., the Director of Nursing indicated the "Level of Service			

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	Assessment/Evaluation" document was not the service plan but how they decided which level of care the resident needed. She indicated the "Evaluation of Needs/Service Plan" was the document they used as their service plan. She indicated there was nothing on the service plan about the resident's colostomy. 3. In an interview during the initial tour on 2/11/12 at 10:30 A.M., LPN #5 indicated Resident #25 was receiving contracted services for Physical/Occupational Therapy, Skilled Nursing, and Home Health Aide. The clinical record for Resident #25 was reviewed on 2/12/13 at 10:00 A.M. Diagnoses included, but were not limited to, diabetes with neuropathy of the lower legs, obesity, degenerative disc disease, overactive bladder, and fatigue. Interdisciplinary Progress Notes entries indicated the resident had been found on the floor on the following dates: 11/29/12 at 7:15 A.M.--"...heard yelling coming from her room... she			

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	was on the floor next to bed screaming hysterically about her blood sugar...." 12/2/12 at 4:00 A.M.--"Staff answered call light and found resident in a sitting position on the floor with her back to her bed facing her window. Resident stated she rolled out of bed. Resident right knee had rug burn from the grip tape on the floor...." 12/8/12 at 6:15 A.M.--"Came into the building seen residents call light going off so I went into the resident's room and she was on the floor...." 12/9/12 at 8:30 A.M.--"... walked into bedroom and noticed she was on the floor next to bed. Resident stated that she slid out of bed...." 12/31/12 at 2:15 P.M.--"... Walked down the hall to her room noticed she was on the floor, she stated she slipped on the floor...." 1/23/13 at 5:00 P.M.--"Resident stated she slipped and felled [sic] in bathroom...." 1/26/13 at 12:20 P.M.--"Resident stated she was trying to use the bathroom and slipped and felled [sic] near the heater on her buttocks, she did scraped [sic] her left shin...." On 2/12/13 at 1:20 P.M., LPN #5 provided a form titled "Level of Service Assessment/Evaluation," dated 7/26 and 11/12/12. She			

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	indicated this was the most recent evaluation of the resident, and was also used as the Service Plan. The form, which used a numerical scoring system to document physical and mental abilities, included the following for Resident #25: "JUDGMENT--Decisions are poor, requiring cueing and supervision in planning, organizing and correcting daily routines. NIGHT NEEDS--Requires care 7 nights a week as well as supervision. Sleeps less than five hours during an eight-hour period. BLADDER CONTROL--Needs assistance daily to manage catheter or sheath changes, urinary ostomy, incontinency or dribbling. MOBILITY--Can only get around with regular assistance or another person both inside and outside. Not safe to ambulate alone. needs constant cueing or standby assistance inside and outside to address safety. Does not have required strength or endurance to use mechanical aids." There was nothing on the form related to the contracted services for therapy, skilled and Home Health aide; and had not been updated to address the residents' multiple falls			

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	and services to be provided by the facility.			

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R0243	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment.			
	Based on observation, record review and interview, the facility failed to give a medication as ordered by the physician for 1 of 5 residents reviewed for medication errors in a sample of 8. (Resident #20) Findings include: The medication pass was completed on February 12, 2013 with QMA #4 (Qualified Medication Aid) at 12:30 P.M. QMA #4 gave medications to Resident #20 on 2/12/13 at 8:45 A.M. The medications she passed were as follows: Lisinopril 20 mg (milligrams) one tablet and Pantazoprole 20 mg one tablet. She asked the resident at this time if she needed anything for pain and the resident stated no. The physician's orders for medications for Resident #20 were reviewed on 2/12/13 at 1:30 P.M.	R0243	1.The physician and responsible party of Resident #29 were notified of the omission. The resident incurred no negative outcome. 2.All residents receiving medications have the potential to be affected. All MARs were reviewed to ensure medications were documented as administered as ordered. No other concerns were noted. 3.All nurses and QMA's will be in-serviced on the facility's policy on medication administration. The DON or designee will complete medication administration observations twice weekly for one month, then weekly for one month, then monthly ongoing to ensure medication administration is completed per facility policy. 4.As a means of quality assurance the DON or designee will complete the above described monitoring ongoing on a monthly basis. Should a deficient practice be observed, immediate corrective action will be taken. The Administrator or designee will monitor and sign off on the	02/28/2013

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	The physician's orders indicated the following medications were to be given at 8:00 A.M. Lisinopril 20 mg one tablet daily by mouth, Pantazoprole 20 mg one tablet daily by mouth, Patanol 0.1% one drop in each eye daily, Neurontin 400 mg one capsule twice daily by mouth. In an interview with the Director of Nursing (DON) on 2/12/13 at 1:40 P.M., she indicated all of Resident #20's medications would be passed during the time allotted. She indicated the usual routine is the resident receives eye drops in her room while sitting in her recliner. The Medication Administration Record for February for Resident #20 was requested at this time. The DON provided the MAR for February 2013 for Resident #20. The MAR boxes for the 8 a.m. time slot for Neurontin 400 mg were blank. In an interview with the DON on 2/12/13 at 1:45 P.M., she indicated the Neurontin 400 mg had not been given.		monitoring tools ongoing. Based upon the findings, the plan of correction will be revised accordingly, if warranted.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0246	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure that a Qualified Medication Aide (Q.M.A.) contacted a licensed nurse to obtain authorization prior to administering PRN (as needed) medications, and documented time and dates for all contacts in the clinical record. This deficiency affected 3 of 3 residents identified as receiving PRN medications administered by facility nursing personnel in a sample of 8 residents. [Residents #25, #27, and #50] Findings include: 1. The clinical record for Resident #25 was reviewed on 2/12/13 at 10:00 A.M. Diagnoses included, but were not limited to, diabetes with lower extremity ulcer, cellulitis, and neuropathy; neck pain, obesity, and degenerative disc disease.	R0246	1.Resident #25, #50, #27 were affected. PRN medications were administered as ordered, although not authorized by the licensed nurse. The involved unlicensed staff has been addressed and re-educated. 2.All residents receiving PRN medications have the potential to be affected. All nurses and QMA's will be in-serviced on the facility's PRN medication administration policy, including receiving appropriate authorization for each administration of a PRN medication. 3.QMAs are to notify a nurse before administering any PRN medication for approval. The DON or designee will document all authorizations given for administration of PRN medications via use of a log. The DON or designee will then check the medical record to ensure accuracy of the documentation for administration of the PRN medication administration and	02/28/2013

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		A. BUILDING 00 B. WING	02/12/2013

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	The MAR (Medication Administration Record) for November, 2012 listed an order, dated 7/13/12, for Hydrocodone APAP (a pain medication) 7.5-750 mg. (milligrams) one tablet every 8 hours PRN. The December 2012 MAR indicated the dosage was changed on 12/11/12 to 7.5-325 mg. one three times a day PRN. The November, 2012 MAR indicated the resident received 12 doses of the PRN medication between 11/16 and 11/29/12. All doses were administered by a Q.M.A., as indicated by initials on the front and back of the MAR. The initials were identified by LPN #5. There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. The December, 2012 MAR indicated the resident received 16 doses of the PRN medication between 12/4 and 12/31/12. All doses were administered by a Q.M.A., as indicated by initials on the front and back of the MAR. The initials were identified by LPN #5.		co-sign accordingly when next on-site in the facility. 4.As a means of quality assurance the DON or designee will complete the above described monitoring ongoing daily on regularly scheduled days of work. Should a deficient practice be observed, immediate corrective action will be taken. The Administrator or designee will monitor and sign off on the monitoring tools monthly ongoing. Based upon the monitoring findings, the plan of correction will be revised accordingly, if warranted.	

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	There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. 2. The closed clinical record for Resident #50 was reviewed on 2/11/13 at 12:25 PM. Diagnoses included, but were not limited to, hypertension, diabetes with neuropathy, lumbo-sacral intervertebral disc degeneration, lumbago, osteoarthritis, cognitive impairment, and depression. The February, 2013 physician order recapitulation sheet included orders for Ativan (an antianxiety medication) 0.5 mg. (milligrams) every 6 hours PRN; and Trazadone (an anti-depressant medication, also used for insomnia) 50 mg. at bedtime for sleep PRN. The October, 2012 MAR (Medication Administration Record) indicated the resident had received a dose of Ativan on 10/7/12. The dose was administered by a Q.M.A., as indicated by initials on the front and back of the MAR. The initials were identified by LPN #5.			

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	There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. The December, 2012 MAR indicated the resident had received 2 doses of Ativan on 12/9 and 12/29/12. All doses were administered by a Q.M.A., as indicated by initials on the front and back of the MAR. The initials were identified by LPN #5. There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. The January, 2013 MAR indicated the resident had received 1 dose of Ativan on 1/26/13, and 4 doses of Trazadone on 1/1, 2, 3, and 4, 2013. All doses were administered by a Q.M.A., as indicated by initials on the front and back of the MAR. The initials were identified by LPN #5. There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A.s had contacted a licensed nurse for authorization prior to administering the medication.			

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	3. The clinical record for Resident #27 was reviewed on 2/12/13 at 9:45 A.M. Diagnoses included, but were not limited to, early congestive heart failure, history of colon cancer and diverticulitis, depression, psychotic episodes, right sided heart failure and acute renal failure. The resident was admitted on 6/3/2011. The Medication Administration Record (MAR) for January 2013 had a PRN (as needed) medication of Vicodin 5/325 mg one tablet by mouth every 6 hours as needed for pain. The box dated for 1/25, 1/28, 1/29 and 1/30 had initials in them and the initials were identified by the Director of Nursing as QMA's (qualified medication aid) initials. The back of the MAR indicated the medication was given and that it was effective with the QMA's initials and time noted. There was no nurses signature or initials by these entries. The nurses notes for 1/25, 1/28, 1/29 and 1/30 did not have any entries indicating the QMA had requested and received permission to give the PRN pain medication. 4. In an interview on 2/12/13 at 10:20 A.M., LPN #5 indicated she was the			

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	only licensed nurse employed by the facility. She indicated the Q.M.A.s would call her one time in the evening around 9:00 P.M., and tell her who they had already given PRN medications to, and she would note it in a log she kept. She indicated as the only licensed nurse, she was not going to have the Q.M.A.s call her each time they needed to administer a PRN medication.			

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R0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and record review the facility failed ensure the kitchen and kitchen equipment was clean and sanitized, and failed to ensure food was held at the proper temperature for 2 of 2 kitchen observations. This deficit practice had the potential to affect 30 of 30 residents residing in the facility. Findings include: The initial tour of the kitchen was completed on 2/11/13 at 10 A.M. There were no staff present in the kitchen at the time the tour began at 10 A.M. In an interview with the Director of Nursing on 2/11/13 at 10 A.M., she indicated the Dietary Manager overslept and would be in shortly. She indicated she and the Activities Director had been in charge of breakfast for the residents. During the kitchen tour, the following was observed:	R0273	1.The sanitation solution was prepared upon arrival of the Dietary Manager. The dirty rags were removed from the sink. The grape jelly was disposed of. The cracked eggs were disposed of. The plastic bag of onions and green peppers was disposed of. The cooler has a thermostat on the outside of it for monitoring the temperature. A thermometer was placed inside of the cooler for monitoring the temperature inside as well. The fan inside the freezer was cleaned. The Styrofoam cup was removed from the flour and disposed of. The slicer was cleaned immediately. The pipe was adjusted to an appropriate position. 2.All residents have the potential to be affected, thus the following corrective actions were taken. The kitchen daily cleaning schedule has been updated to include cleaning and disinfecting the slicer. The kitchen monthly cleaning schedule has been updated to include cleaning the fan in the walk in freezer. Administrative staff has addressed necessary action to be taken in the absence of scheduled dietary staff, and applicable personnel will be	02/28/2013

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	There was no sanitation solution prepared. There were dry dirty rags sitting over the edge of the three compartment sink. There was a tub of grape jelly undated and unlabeled sitting out on one of the counters, it was warm to touch. There was a cooler beside the fryer area and inside of it there were approximately 18 stacks of eggs. It was noted two of the stacks of eggs had eggs with cracks in them, dried in place. There was an unsealed plastic bag of chopped onion and green peppers with moisture accumulated inside the bag. There was no thermometer inside to tell the environmental temperature. The walk in freezer had a fan that was covered with a dusty debris. There was a Styrofoam cup inside of the flour. The meat shredder had dried pink debris on the cutting surface. There was a pipe coming out of the walk-in refrigerator onto the floor lying		trained appropriately with said training documented. 3.All dietary staff will be in-serviced on the new cleaning schedule, monitoring food temperatures, sanitizing the food slicer, utilizing sanitation buckets, food storage and using food & equipment thermometers. 4.As a means of quality assurance the Dietary Manager will conduct a periodic walk through of the kitchen which will include, but not be limited to checking the food slicer, walk in freezer fan, and proper sanitization bucket to ensure all tasks are being completed . This will be conducted at least three times weekly ongoing. The Dietary Manager or designee will sign at the bottom of each daily cleaning assignment sheet to verify that all tasks have been completed. The daily and monthly cleaning schedules will be reviewed and signed off monthly ongoing by the Administrator or designee.	

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	on top of a vented surface. The Dietary Manager (DM) arrived on 2/11/13 at 10:17 A.M. During interview at that time, she indicated they usually prepare sanitation solution first thing in the morning when she arrives around 7:00 A.M. She indicated the tub of jelly was usually dated and the label must have fallen off. She indicated there were clean rags that staff use for sanitizing counters. The cooler besides the fryer was checked and she indicated she monitored the temperature by checking the gauge on the bottom right side on the outside of the cooler for it's proper temperature and that there was no thermometer on the inside of the cooler. She leaned over and squatted saying the temperature was 40 degrees currently. She indicated she used eggs for all baking, cooking and preparation of eggs for breakfast food. The DM indicated she did not clean the fan in the freezer and was not certain whose responsibility it was, she thought it was probably maintenance. She also indicated if she was sick there was really no one to take her place as she is the only one scheduled for the early A.M., shift and no one else comes in until 12 P.M.			

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	On 2/11/13 at 12:40 P.M., the DM checked the food temperatures of the Salisbury steak, mashed potatoes and peas and carrots with a thermometer. She took the thermometer out of a pocket in the front of her apron. She pulled the thermometer out of it's protective sleeve. She then stuck it into the Salisbury steak. After obtaining a temperature, she removed the thermometer from the meat and wiped it off with a dry paper towel, and then stuck the thermometer into the mashed potatoes. After obtaining a temperature, she removed it from the food and again wiped with dry paper towel. She then stuck thermometer into the peas and carrots, wiped it with a dry paper towel, placed it into the protective sleeve and back into the pocket of her apron. The policies and cleaning lists were provided by the Administrator on 2/12/13 at 9:25 A.M. At that time, she indicated the thermometer should have been cleaned with an alcohol wipe. She also indicated they only had training for the actual kitchen staff as well as the Activity Director, but they did not have documentation indicating training for the Director of Nursing to work in the kitchen.			

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	The policy for sanitizing the slicer dated 11/12/08 indicated, "...It is necessary to clean and sanitize the slicer after each use..." The policy for sanitation buckets dated 11/12/08 indicated, "...Sanitation buckets must be available in the Dietary Department at all times 1. Employees should make 1 bucket for food contact surfaces...." The policy for Food & Equipment Thermometers dated 11/12/08 indicated, "...Thermometers are used to ensure that food storage units (refrigerator/freezers and food products are at proper temperatures to prevent bacterial growth...1. Thermometers should be easy to locate and placed at eye level...." The policy for Food Temperatures on Service Line dated 11/12/08 indicated, "...1. Wash, rinse and sanitize dial face thermometer with alcohol wipe. Re-sanitize the thermometer after each use...." The cleaning schedule for January indicated, "wk 1, wk 2, wk 3, wk 4 and wk 5 ...sweep and mop freezer and fridge floor....clean and sanitize slicer...."			

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R0349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to have correct documentation of code status for 2 of 8 residents, and correct demographic information for 1 of 8 residents reviewed for documentation in a sample of 8. (Resident #9, #13, and Resident #14) Findings include: 1. The clinical record for Resident #13 was reviewed on 2/11/13 at 10:30 A.M. Diagnoses included, but were not limited to, end stage congestive heart failure, high blood pressure, hypothyroidism, benign prostatic hyperplasia and osteoarthritis. The documentation on the face sheet dated 8/31/12, indicated the resident was a DNR (do not resuscitate). The documentation on the choice of treatment, dated 6/1/11, indicated the	R0349	1.The medical records of Residents # 13, #14, and #9 were reviewed and documentation updated to accurately reflect code status and demographic information. 2.All residents have the potential to be affected, thus, all residents' medical records were audited to ensure the code status, birth date, and admission date were all correct on all documents throughout the charts. Corrections were made as needed. 3.Contracted healthcare services will be addressed to ensure that any change made in regard to code status is communicated to the DON at the time of said change. The DON or designee will complete an audit tool monthly ongoing to ensure the birth date, admission date, and code status are correct in the medical record and on the rewrites. 4.As a means of quality assurance, the Administrator will	02/28/2013

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	resident wanted to have CPR (cardio pulmonary resuscitation). The IDT (Inter Disciplinary Team) Hospice Care plan dated 12/28/12 indicated the resident was a DNR. A request was made of the Director of Nursing (DON) on 2/11/13 at 11:00 A.M., for the information that is used for the staff to identify whether a resident is to be given CPR or if they are a DNR. The DON provided a list of all of the residents and whether they were CPR or DNR on 2/11/13 at 11:50 A.M. The list indicated Resident #13 was to have CPR. In an interview with the Director of Nursing on 2/11/13 at 1:15 P.M., she indicated the resident had been switched from a full code status to a DNR by hospice in December 2012. She provided a document titled "State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order" dated 12/28/12. She indicated she was unaware this had been done. 2. The clinical record for Resident #14 was reviewed on 2/11/13 at 11:30 A.M. Diagnoses included, but were not limited to, dementia, high		monitor to ensure the ongoing audits are completed on a monthly basis ongoing. The Administrator or designee will initial the form when reviewed. Should a deficient practice be observed, immediate corrective action will be taken. Based upon the findings, the plan of correction will be revised accordingly, if warranted.	

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	blood pressure, and depression. The documentation on the face sheet dated 8/10/12, indicated the resident was a DNR (do not resuscitate). The documentation on the choice of treatment, dated 6/1/11, indicated the resident wanted to have CPR (cardio pulmonary resuscitation). The physician's recapitulation for February 2013 indicated the resident was a DNR. A request was made of the Director of Nursing (DON) on 2/11/13 at 11:00 A.M., for the information that is used for the staff to identify whether a resident is to be given CPR or if they are a DNR. The DON provided a list of all of the residents and whether they were CPR or DNR on 2/11/13 at 11:50 A.M. The list indicated Resident #14 was to have CPR. 3. The clinical record review for Resident #9 was completed on 2/12/13 at 9:15 A.M. Diagnoses included, but were not limited to, neonatal encephalitis, left sided stroke with left sided weakness and bipolar disease.			

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	The face sheet dated 1/29/2013 indicated the resident was admitted 1/28/13 and the residents birth date was 3/22/55. The pre-placement assessment form indicated the resident's date of birth was 8/22/55. The physician's recapitulation for February 2013 indicated the residents date of birth was 3/22/55 and the admission date was 3/30/12. In an interview with the DON on 2/12/13 at 2:00 P.M., she indicated the DNR status was incorrect for Resident # 13 and # 14 and the admission date and birth date for Resident # 9.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF CARMEL	11610 TECHNOLOGY DR CARMEL, IN 46032

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R0378	410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) Mental Health Screening- Deficiency (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but not be limited to, the following: (1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia. (B) Schizoaffective disorder. (C) Mood (bipolar and major depressive type) disorder. (D) Paranoid or delusional disorder. (E) Panic or other severe anxiety disorder. (F) Somatoform or paranoid disorder. (G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise specified). (2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual. Based on interview and record review, the facility failed to provide a pre-admission individual needs evaluation, which included a screen for major mental illness, history of treatment for a major mental illness within the last 2 years, and a history of individual behavior within the last 2 years that would be considered dangerous to the facility residents, staff, or individual. This deficiency affected 2 of 5 residents receiving a	R0378	1.Residents # 9 and #29 have not exhibited problematic behaviors while residing in the facility and are being treated as ordered. 2.All current residents diagnoses were reviewed to ensure that all residents with a major mental illness are receiving necessary treatment, if warranted. The prospective resident assessment (i.e., pre-placement assessment) has been revised to ensure all new	02/28/2013

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	Medicaid waiver for payor status, in a sample of 8 residents. (Residents #9 and #29) Findings include: 1. The clinical record review for Resident #9 was completed on 2/12/13 at 9:15 A.M. Diagnoses included, but were not limited to, neonatal encephalitis, left sided stroke with left sided weakness and bipolar disease. The resident was admitted 1/28/13. The resident had a pre-placement assessment form dated 12/7/12. The form indicated the resident had a diagnosis of bipolar. There was no mention on this form regarding any behaviors, hospitalizations or otherwise. The chart had notes under the consultant tab which contained psychotherapy notes for Resident #9. The dates included were: 9/10/12, 9/24/12, 10/15/12, 10/22/12 and 11/12/12. The psychotherapy notes provided from the resident's prior skilled nursing placement indicated "... was seen for psychotherapy for follow up due to verbally and physically		inquiries to the facility will have an assessment completed to include screening for a major mental illness. 3.The Director and DON will be educated on the completion of the Prospective Resident Assessment form, including the completion of the screening for major mental illness and necessary referral, if indicated. 4.As a means of quality assurance the Administrator or designee will monitor to ensure the Prospective Resident Assessment has the questions regarding major mental illness completed, as appropriate, ongoing, The Administrator will initial the form when reviewed. Should a deficient practice be observed, immediate corrective action will be taken.	

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	aggressive behaviors. Patient documented to show persistent aggressive behaviors toward staff and residents... appears to be showing increasing manic symptoms which appear to interfere significantly with interpersonal interactions and level of agitation at this time...." A 10/22/12 note indicated "...patient reportedly made verbally aggressive statements toward another resident. He admitted to episode however appeared indifferent to inappropriateness of behavioral response. Patients expressed his frustration over the monitoring from staff..." There was no documentation of screening or evaluation of Resident #9 from the facility in regards to major mental illness prior to admission. In an interview with the Director of Nursing on 2/12/13 at 2:15 P.M., she indicated this was all the information the facility had on the resident pertaining to assessment or evaluation of resident prior to admission. She indicated she was not aware of the status of his meeting with the mental health service provider or it's frequency, or the date of the last visit.			

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	2. The clinical record for Resident #29 was reviewed on 2/12/13 at 12:20 P.M. The resident was admitted on 1/26/13 with diagnoses that included, but were not limited to, diabetes, coronary heart disease with a pacemaker, congestive heart failure, and depression. A pre-admission needs evaluation, which would include a screen for major mental illness, a history of major mental illness in the previous 2 years, and a history of any behaviors, was not found. On 2/11/13 at 11:30 A.M., LPN #5 provided a list of current residents receiving services from the facility consultant psychologist. She indicated she had started paperwork for two other current residents to have an evaluation by the psychologist, but that Resident #29 was not one of them. She indicated Resident #29 was not currently receiving any psychiatric services.			

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R0383	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on interview and record review, the facility failed to provide coordination and development of care plans with mental health service providers, for 3 of 5 residents reviewed for mental health care plans in a sample of 8. (Resident #9, Resident #50 and Resident #27) Findings include: 1. The clinical record review for Resident #9 was completed on 2/12/13 at 9:15 A.M. Diagnoses included, but were not limited to, neonatal encephalitis, left sided stroke with left sided weakness and bipolar disease. The resident was admitted 1/28/13.	R0383	1.The Service Plans of applicable residents were updated to include pertinent diagnosis, interventions, preferences, any need for mental health services, and how the residents needs will be met. 2.As all potential or current residents have the potential to be affected, all new inquiries to the facility will have an assessment completed to include screening for a major mental illness, as well as all current residents with a major mental illness identified. Should services be necessary, the same shall be sought. Any services shall be addressed on the Service Plan to include pertinent diagnosis, interventions, preferences, any need for mental health services, and how the residents' needs will	02/28/2013

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	The resident had a pre-placement assessment form dated 12/7/12. The form indicated the resident had a diagnosis of bipolar. There was no mention on this form regarding any behaviors, hospitalizations or otherwise. The chart had notes under the consultant tab which contained psychotherapy notes for Resident #9. The dates included were: 9/10/12, 9/24/12, 10/15/12, 10/22/12 and 11/12/12. The psychotherapy notes provided from the resident's prior skilled nursing placement indicated 9/10/12 , "... was seen for psychotherapy for follow up due to verbally and physically aggressive behaviors. Patient documented to show persistent aggressive behaviors toward staff and residents...appears to be showing increasing manic symptoms which appear to interfere significantly with interpersonal interactions and level of agitation at this time...." The notes indicated on 10/22/12, "...patient reportedly made verbally aggressive statements toward another resident. He admitted to episode however appeared indifferent		be met. 3.The Director and DON will be educated on the Pre-Placement Assessment form updates to include screening for major mental illness, as well as required documentation on service Plans to ensure coordination of services. The DON or designee will review and update all service plans on a quarterly basis and as needed with changes. The DON or designee will complete an ongoing audit on a monthly basis of at least three (3) service plans to ensure all service plans are updated with current issues and interventions. 4.As a means of quality assurance the Administrator or designee will monitor to ensure the Pre-Placement Assessment form has the questions regarding major mental illness completed and the Service Plan includes pertinent diagnosis, interventions, preferences, any need for mental health services, and how the residents needs will be met monthly ongoing. The Administrator will initial the form when reviewed. Should a deficient practice be observed, immediate corrective action will be taken. Based upon the monitoring, the plan of correction will be revised accordingly, if warranted.	

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	to inappropriateness of behavioral response. Patients expressed his frustration over the monitoring from staff..." The document titled "Service Plan," dated January 28, 2013, indicated nothing on pertinent diagnoses, interventions, or social needs and preferences. There was nothing documented regarding a need for mental health services and how they were going to meet Resident #9's individual mental health needs. In an interview with the Director of Nursing on 2/12/13 at 2:15 P.M., she indicated this was all the information the facility had on the resident for a service plan. She indicated she was not aware of the status of his meeting with the mental health service provider or it's frequency, or the date of the last visit. 2. The clinical record for Resident #27 was reviewed on 2/12/13 at 9:45 A.M. Diagnoses included, but were not limited to, early congestive heart failure, history of colon cancer and diverticulitis, depression, psychotic episodes, right sided heart failure and acute renal failure. The resident was admitted on 6/3/2011.			

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	The notes from the agency providing psychiatric services indicated on 11/27/12, "...seen for obsessive thoughts and compulsive behaviors...no recent behavioral disturbances or psychotic thinking are documented in the chart...." The document titled "Evaluation of Needs/Service Plan was dated 7/26/12, with a revision date of 1/8/13. The section noted at individual needs assessment (complete if resident has a mental health diagnosis) was left blank. There was nothing documented regarding a need for mental health services and how they were going to meet Resident #27's individual mental health needs. In an interview with the Director of Nursing on 2/12/13 at 2:17 P.M., she indicated this was all the information the facility had on the resident for a service plan. She indicated the resident had a history of psychotic episodes prior to admission to the facility. She indicated she was not aware of the status of his meeting with the mental health service provider or it's frequency, or the date of the last visit.			

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	3. The closed clinical record for Resident #50 was reviewed on 2/11/13 at 12:25 P.M. The resident was admitted to the facility on 3/27/12 with a Medicaid waiver payor status. Diagnoses included, but were not limited to, diabetes with neuropathy, morbid obesity, degenerative disc disease, osteoarthritis, urinary incontinence, altered mental status, and depression. She was discharged to a skilled nursing facility in February, 2013. Reports from 10/7/11 and 11/14/11 indicated the resident had been followed by psychiatric services in another facility. A psychiatric evaluation completed on 4/11/12 indicated the resident also had diagnoses of bipolar disease, anxiety, and dementia. A note in the evaluation indicated the resident denied bipolar disease but acknowledged depression, and had a history of leaving previous facilities AMA (against medical advice). The resident continued to receive psychiatric follow-up services following her admission to CrownPointe. On 2/12/13, LPN #5 provided a form titled "Evaluation of Needs/Service			

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	Plan." The "Service Plan Record of Review" page indicated the Service Plan had been reviewed on 7/26/12, 10/8/12, and 1/13/13. The Service Plan, in cooperation with the mental health service provider, did not address the psychosocial rehabilitation services to be provided within the community, a comprehensive range of activities to meet multiple levels of need including recreational and socialization activities, social skills, potential training/occupational/work programs, or opportunities for progression into less restrictive and more independent living arrangements. In an interview on 2/12/13 at 11:15 A.M., LPN #5 indicated she thought listing the mental illness diagnoses and medications on the Service Plan was sufficient.			